Initial Clinical Assessment for Children

NAME / MRN ____________________

BILLING

Program Name: ________________________________ FAC/PROG: ____________ Date: ______________

Provider #: ______________ Min(s): _________ Code Activity ☐ 331 Assessment ☐ 580 Lockout

Is Client Pregnant? ☐ **Yes** ☐ **No** *Travel Time To/From included in above (if applicable) Hrs ______ Mins ______*

Location of Services: (Please check one)

☐1 Office	☐5 School	☐11 Faith-Based	☐15 LicCommCarefac (adult)	☐19 Res Tx Ctr (child)
☐2 Field	☐8 Cor Fac	☐12 Healthcare	☐16 Mobile Service	☐20 TeleHealth
☐3 Phone	☐9 Inpatient	☐13 Age-spec Com ctr	☐17 Non Trad Svc Loc	☐21 Unknown
☐4 Home	☐10 Homeless/shelter	☐14 Client's job site	☐18 Other	

Service Strategies: (Check up to three, if applicable)

☐50 Peer/Fam DelivSvcs	☐53 Supportive Education	☐56 Ptnrshp:Soc Svcs	☐59 Integrated Svcs: MH-Dvlp Disabled	
☐51 Psych Education	☐54 Prtnrshp:Law Enfcmt	☐57 Ptnrshp:Subs Abuse	☐60 Ethnic Specific Service Strategy	
☐52 Family Support	☐55 Ptnrshp:Health Care	☐58 IntSvcs:MH/Aging	☐61 Age-Spec Svc Strategy	☐99 Unknown

Language:

Primary Language: ______________________ Other Languages spoken in home: ________________________

☐ **Interpreter** Name of Interpreter: ________________________________

Language service provided in other than English: ☐ Spanish ☐ Other ______________________

Identifying Information:

Name: ____ ☐ Male ☐ Female DOB: ______________

Address: ____ Phone: _____________

Referred by: ____

CLIENT AND LEGAL INFORMATION

Lives with: ☐ Immed. Family ☐ Extend. Family ☐ Unrel. Foster Family ☐ Jail/Juvenile Hall
☐ Acute Hospital ☐ Group Home ☐ Emergency Foster Care ☐ Residential
☐ Other____________

Residential Contact
(Name & Phone):
____

Others in Home/Ages/Relationship to Child:

____

Compostion of Family of Origin (if different from above):

NAME / MRN ______________________

Current Legal Status:

☐ Independent Adult ☐ Child in custody of biological Parent(s), Adpotive parent(s) ☐ Emancipated Minor

☐ Juvenile Dependent of Court ☐ Juvenile Ward of the Court (Probation 602) ☐ Other ______________________

Agencies/Other MH Providers Involved: (check all that apply, including contact names & phone numbers as appropriate)

☐ CC Mental Health Clinic___________________________ ☐ CFS____

☐ CBO____ ☐ Network Provider________________________________

☐ Regional Center_________________________________ ☐ Probation_____________________________________

☐ Other____

BEHAVIORAL/EMOTIONAL NEEDS

What is the primary reason for current referral? Describe current precipitating event, primary stressors, primary symptoms and functional impairment.

Developmental History: ☐ Birth and Developmental History is not available.

Birth was: ☐ On-Time ☐ Early (< 36 weeks) ☐ Late

While Pregnant, did mother have any injuries, illnesses, physical trauma or use alcohol/drugs?	☐ No	☐ Yes
Were there any complications at time of birth?	☐ No	☐ Yes
Did the child experience any traumas during first 5 years?	☐ No	☐ Yes
Did the child have any sleep, eating, or social problems the first 5 years?	☐ No	☐ Yes

If "yes" to any of the above, please describe:

____

Developmental Milestones: Early On-Time Delayed (If delayed, please describe):

NAME / MRN

Family/Social History: (Summarize relevant data regarding significant interpersonal relationships (i.e. parents, siblings, etc.), living situations, family history or mental illness or substance abuse, and/or relevant traumatic events/losses)

Medical History: Not available

Current Primary Medical Provider: ______________________________ ☐ None ☐ Unknown

Date of Last Physical Exam: ______________________________ ☐ Unknown

Date of Last Dental Exam: ______________________________ ☐ Unknown

Are there any health concerns (medical illness, medical symptoms) regarding this child? No Yes (if so, please describe):

Has the child had any allergic/serious reactions to medication(s)? No Yes (if so, please describe):

Has the child had any NON medication allergies (food, pollen, bee stings, etc.)? No Yes (if so, please describe):

NAME / MRN

Is the child taking any medications? If yes, List name of any medication(s) child is taking at this time: (list all current medications including OTC, herbal, psychiatric, and homeopathic. Include start date/dose/frequency) None

Medication compliance issues? N/A No Yes (if yes, please describe)

☐ Referral to Health Care Provider for further Evaluation/Assessment

Treatment History: ☐ None ☐ Unknown

☐ Psych Hospitalization ☐ Psych Medication ☐ Residential Treatment ☐ Day Treatment
☐ Substance Abuse Program ☐ Psychotherapy ☐ Testing- Psychological/Neurological/Educational
☐ Previous Crisis Contact ☐ Use of Non Traditional or Alternative Healing Practices

Comments on above history:

Substance Use History: ☐ No Current or Past Substance Abuse ☐ Unknown

☐ Actively Using Substances ☐ Currently Clean & Sober for: ☐ < 6 months ☐ > 6 months ☐ > 1 year

Please check all substances used in the past 6 months:

Past	Present		Frequency
☐	☐	Alcohol	___________________________
☐	☐	Amphetamine	___________________________
☐	☐	Caffeine	___________________________
☐	☐	Cocaine/Crack	___________________________
☐	☐	Designer Drugs (GHB, PCP, Ecstasy)	___________________________
☐	☐	Hallucinogens (LSD, Mushrooms)	___________________________
☐	☐	Inhalants (Paint, Gas, Aerosols)	___________________________
☐	☐	Marijuana	___________________________
☐	☐	Opiates (Heroin, Opium, Methadone)	___________________________
☐	☐	Over the Counter_____________	___________________________
☐	☐	Pain Killers (Oxy, Norco, Vicodin)	___________________________
☐	☐	Other_______________________	___________________________

Comments:

NAME / MRN

Education History: ☐ N/A Child is under 5 years old

Current School: ________________________________ Grade: _______________ Contact: __________________________________

RISK BEHAVIORS ☐ None Identified

Danger to self (intent, plan means): ____

Past: ____

Danger to others (intent, plan, means): ____

Past: ____

Grave Disability (unable to make use of available resources): ____

5150 Initiated CPS Referral/Involvement Tarasoff Weapons Confiscated

Criminal Justice History: None Unknown

Probation Parole

Probation/Parole Officer Contact: ____ Obtain Release (ROI)

Offense History (include

jail/juvenile hall facility):

Comments:

MENTAL STATUS EXAM

General (appearance, attitude, behavior, speech): ____

Orientation: ____

Mood/Affect: ____

Memory ____

Thought Process: ____

Thought Content: ____

Insight/Judgment/Impulsivity: ____

Additional Observation(s): ____

NAME / MRN ______________________________

Diagnostic Impression: DSM 5 Diagnosis and Narrative, ICD 10 Code

DSM-5 Diagnosis: ________________________ (Primary) **AND** ICD-10 Code: ___________________
DSM-5
Diagnosis Title/Narrative: ____

DSM-5 Diagnosis: ________________________ (Secondary) **AND** ICD-10 Code: __________________
DSM-5
Diagnosis Title/Narrative: ____

DSM-5 Diagnosis by: _____________________________________
(Name of Diagnosing Clinician/Licensure)

INITIAL TREATMENT PLAN

Additional Comments:

____ ________________________________ ____________________
Clinician Signature/Licensure | Printed Name | Date

____________________________________ ________________________________ ____________________
Co-Signature of Licensed Clinician | Printed Name | Date

____
Data Entry Clerk Initials

NAME / MRN

Space for Data Continuation (Specify which item you are continuing from)